Authorization for the Use or Disclosure of Health Information

It is important for your health information to be shared with all of your health care providers to ensure that you receive the best care possible. The purpose of sharing your health information with your providers or supports is to assist in identifying any follow-up medical care that may be needed.

Please allow Beacon Health Options of Kansas and your treatment team to share your health information with each other by signing the release of information below, or having a person who is legally authorized to act on your behalf sign. We will only send and receive information that pertains to your care.

Member/Individual Name:	
Member/Individual ID or Social Security Number:	
Member/Individual Date of Birth:	

Authorization for Disclosure of Health Information

I hereby authorize the parties identified below to disclose (send and receive) my health information to the other parties identified in this document for a period of six months.	**Information to Which This Authorization Applies: 42 CFR regarding substance abuse confidentiality requires as limited information be disclosed as possible, please only check the box(s) that apply**
Beacon Health Options of Kansas 100 SE 9th St., Suite 501 Topeka, KS 66612 Toll Free - (866) 645-8216 Fax – (785) 338-9020 **Regional Alcohol and Drug Assessment Center (RADAC)** Name _____ Address_____ Phone_____ Fax_____ **Physical Health Plan/Medical Provider** Name _____ Address_____ Phone_____ Fax_____ Name _____ Address _____ Phone _____ Fax _____	**Physical and Mental Health** ☐ All health information pertaining to any medical history, mental or physical condition, and treatment received (including services provided at a Community Mental Health Center and/or information related to HIV/AIDS status) in the possession, custody or control of the parties identified in this document, regardless of when such information was generated. This authorization does not include substance abuse records. **Substance Abuse** ☐ I specifically authorize the release of personal health information from my drug and alcohol assessment. The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information. 42 CFR §2.32 restricts any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient. Initials: ____ **Specific Information** ☐ The following records or types of SUD/health information (including any dates): Information _____ Date Range _____ _____ _____ _____ _____ _____ _____

Initials:____ Date:_____

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Notice of Rights and Other Information

Understand and Agree to the following:

- I have the right to review the information that is being disclosed;
- The recipient of this disclosed information does not have my permission to re-disclose it; however, I understand that this information may be at risk for re-disclosure by the recipient, and no longer protected by federal privacy laws;
- The provider cannot condition my treatment on whether I sign this authorization.
- I have a right to revoke this authorization at any time by sending written notice to Beacon Health Options. Revoking this authorization will not have any effect on actions that Beacon Health Options took in reliance on the authorization prior to receiving notification. For your convenience, a "Revocation of Authorization" Form may be obtained from Beacon Health Options**.** Beacon Health Options does not accept partial revocations. If you wish to partially revoke this authorization, please submit a revocation and new authorization specifying the information you are authorizing for disclosure.
- This Release pertains only to information obtained by the coordinating agency, and does NOT include the member's chart, housed at the provider's office.
- If you authorized release of alcohol or substance use information to a healthcare organization that is not your treating provider, for the next two years, you have the right to find out who within that organization actually saw your information. You should contact the organization directly for that information.
- The coordinating agency will not receive compensation from a third party for using or disclosing this information, and
- I have the right to a copy of this form after I sign it.

I would like a copy of this form: YES Initials: _____

Signature of the Individual and/or the Individual's Legally Authorized Representative** **Date**

Relationship to the Individual/Member:

☐ Self ☐ Parent of Minor Child ☐ Legally Authorized Representative**
(*Legal Guardian) Nature of relationship*

Witness Name **Date**

Witness Agency:

*** Anyone over 14 years of age must sign this release for themselves, if substance abuse information is to be released. If mental health information is to be released and the individual is under 18 years of age, then the Legally Authorized Representative must also sign. If the Individual has been adjudicated and found to be incompetent in a court of law, the Legally Authorized Representative may sign this consent form on behalf of the Individual. If you are signing as a Legally Authorized Representative attach a copy of the appropriate legal document(s) granting you the authority to do so. You do not have to attach copies of documents if you already have those documents on file with Beacon Health Options. My legal documents granting authority to act on the individual's behalf are already on file with Beacon Health Options*:

☐ YES Initials: _____